MDR Tracking Number: M5-04-1331-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 12, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 01/12/04, therefore the following date(s) of service are not timely: 01-09-03 and 01-10-03

Date of service 03-21-03 was withdrawn by requestor.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, hot/cold pack therapy, office visits w/manipulation, electric stimulation, ultrasound therapy, neuromuscular re-education, therapeutic activities, unlisted special service/report, unusual travel and team conference were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 01-14-03 to
03-14-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day April 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

April 15, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: MDR #: M5-04-1331-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
Correspondence
H&P and office notes
Physical therapy notes
Operative and radiology reports

Clinical History:
Patient is a 30-year-old male who was injured his left foot on ___ in a work-related accident. He eventually underwent surgery, followed by post-operative physical medicine treatments.

Disputed Services:
Therapeutic exercises, hot/cold pack therapy, office visits w/manipulation, electric stimulation, ultrasound therapy, neuromuscular re-education, therapeutic activities, unlisted special service/report, unusual travel, and team conference during the period of 01/14/03 through 03/14/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
After surgical repair, 6-8 weeks of therapeutic rehabilitation would be considered medically indicated. That therapy was performed for the 7-week period from 11/26/02 to 01/10/03. Although the treatment did not substantively decrease the patient's pain, it was nevertheless medically indicated.

However, since the care to that point failed to offer any significant benefit, continued treatment of the same type beyond that time would not be medically necessary. The medical records document the ineffectiveness of the care with a pain rating of 4 on 11/26/02 and remaining at 4 on 02/21/03. Further documentation of the patient's lack of response is contained the doctor's daily notes that repeatedly state, "No change in symptomatology since yesterday" and "No change in his condition since previous treatment." Therefore, the medical necessity of performing more of the same for longer time cannot be supported.

Sincerely,